TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF ARLINGTON

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-0172-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is not the Insurance Carrier's assumption what determines an emergency. It is the Patient's belief that their condition based on the onset of their symptoms requires emergent care."

Amount in Dispute: $335.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The emergency department physicians assistant documented, basically, a negative physical exam, . . . Texas Mutual reviewed the documentation and found it did not document an emergency consistent with the definition of such at Rule 133.2."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2015	Outpatient Hospital Emergency Room Visit	$335.25	$219.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
4. 28 Texas Administrative Code §133.3 sets out requirements for communication between carriers and providers.
5. 28 Texas Administrative Code §133.210 sets out requirements regarding medical documentation.
6. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
7. 28 Texas Administrative Code §133.250 sets out requirements for reconsideration of payment for medical bills.
8. 28 Texas Administrative Code §133.500 establishes standards and formats for electronic medical bill processing.
9. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.

10. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
11. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
    - 18 – EXACT DUPLICATE CLAIM/SERVICE
    - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
    - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
    - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
    - 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.
    - 822 – THE PAYER HAS NOT SUPPLIED US WITH THE APPROPRIATE DOCUMENTATION TO REVIEW YOUR BILL. PLEASE SUBMIT THE REQUESTED INFO TO THE PAYER.
    - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
    - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
    - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Does the medical documentation lack information necessary to adjudicate the bill?
2. Does the documentation support an emergency?
3. Are the insurance carrier's denial reasons supported?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
    - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
    - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
    - 822 – THE PAYER HAS NOT SUPPLIED US WITH THE APPROPRIATE DOCUMENTATION TO REVIEW YOUR BILL. PLEASE SUBMIT THE REQUESTED INFO TO THE PAYER.

    Review of the respondent's submitted information finds no description of the alleged billing errors, the information lacking, or the clarifying information needed for adjudication of the claim. The respondent thus did not give plain language notice to the requestor of the information requested, any errors in the billing, or appropriate documentation required to review the bill.

    28 Texas Administrative Code §133.210(d) requires that any request by the insurance carrier for additional documentation to process a medical bill shall:

    (1) be in writing;
    (2) be specific to the bill or the bill's related episode of care;
    (3) describe with specificity the clinical and other information to be included in the response;
    (4) be relevant and necessary for the resolution of the bill;
    (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
    (6) indicate the specific reason for which the insurance carrier is requesting the information; and
    (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted information finds that the insurance carrier's request for additional information does not describe with specificity the clinical or other information to be included in the response.
The division therefore finds the above denial reasons do not meet the requirements of Rule §133.210(d).

28 Texas Administrative Code §133.210(e) still further provides that:

> It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

The division therefore finds that insurance carrier denial reason code 822, with respect to the assertion that "THE PAYER HAS NOT SUPPLIED US WITH THE APPROPRIATE DOCUMENTATION TO REVIEW YOUR BILL," does not meet the requirements of Rule §133.210(e) and is not supported.

Review of the submitted medical documentation finds that the information is sufficient to adjudicate the claim and that the documentation supports the disputed service(s) as billed (as will be discussed further below).
The division finds that the insurance carrier's above denial reasons are not supported.

2. The insurance carrier denied the disputed service(s) with claim adjustment reason code 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2."

   This denial reason does not, in and of itself, preclude payment; the Texas Workers' Compensation Act, at Labor Code Section 408.021 provides that "an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." The entitlement is not limited to emergency care, and an emergency is not a prerequisite for payment of treatment for a covered injury.

   While medical emergency may be an *exception* to certain other denial reasons, the insurance carrier has not raised any of those on the EOBs. Discussing an exception does not raise a material defense by implication. The division finds the respondent has not presented any such defenses to the health care provider—and may not do so now.

   Corresponding Rule 28 Texas Administrative Code § 133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   28 Texas Administrative Code §133.240(e) requires that:

   > The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title . . . The explanation of benefits shall be sent to:
   > (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill . . .

   28 Texas Administrative Code §133.250(g) requires that:

   > The insurance carrier shall take final action on a reconsideration request of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:
   > (1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or
   > (2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

   Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

   > (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . .
   > (B) denying a charge on the medical bill.

   All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules.

28 Texas Administrative Code §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

> a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

Review of the submitted information finds no explanations of benefits with denial reasons supporting an independent basis for denying payment to which the requirement of an emergency would be an exception.

Rule §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The insurance carrier's failure to assert on the explanations of benefits specific denial reasons or defenses relating to the services in dispute during the bill review process—before the request for MFDR—constitutes grounds for the division to find a waiver of any such new defenses at Medical Dispute Resolution.

The division finds that the respondent has waived any new denial reasons or defenses not previously raised and is therefore limited to the EOB denial reasons and defenses presented to the requestor before MFDR, as listed above. Review of the insurance carrier's denial reasons finds that the respondent has not established an independent grounds for denying the bill—and specifically has not raised any defenses to which the existence of an emergency would be relevant as an exception. Consequently, the question of whether an emergency existed is not relevant to payment of the bill.

Nevertheless, review of the submitted documents finds the record actually does support a medical emergency.

Rule §133.2(5)(A), defines a medical emergency as:

> the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
> (i) placing the patient's health or bodily functions in serious jeopardy, or
> (ii) serious dysfunction of any body organ or part.

The division notes the rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

Review of the Emergency Department Provider Notes finds that the injured employee presented to the emergency room manifesting acute symptoms including "right thumb pain" which was described as "constant in duration and 9/10 in severity." In the Triage Vitals section, the pain level is listed as "9."

The submitted documentation describes symptoms including severe pain—which meets the requirements of the definition in Rule §133.2(5)(A) sufficient to support a medical emergency.

The division concludes the respondent has failed to support denial of payment based on lack of emergency. The disputed service will therefore be reviewed for payment according to applicable division rules and fee guidelines.

3. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per Rule §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment shall be multiplied by 200 percent.

4. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99282 has status indicator V denoting an emergency department visit. This service is classified under APC 0613, which, per OPPS Addendum A, has a payment rate of $112.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $67.67, multiplied by the annual wage index of 0.9572 yields an adjusted labor-related amount of $64.77. The non-labor related portion is 40% of the APC rate, or $45.12. The sum of the labor and non-labor related amounts is $109.89. The cost of this item does not exceed the annual fixed-dollar threshold of $2,775; thus, the outlier payment is $0. The Medicare facility specific reimbursement amount is $109.89. This amount multiplied by 200% yields a MAR of $219.78.

5. The total recommended reimbursement for the services in dispute is $219.78. The insurance carrier has paid $0.00, leaving a payment due the requestor of $219.78. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $219.78.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $219.78, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	March 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.